TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3304-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 1-8-15, this request was in response to $183.83 no pay of the $183.83 for the Follow Up performed on 11-13-14. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $183.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed code 99214. Texas Mutual reviewed the documentation with the billing. It does not meet 2 of the 3 criteria for billing that code. The exam is problem focused and the medical decision making is straight forward, neither of which rises to the level of 99214.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2014	Evaluation & Management, established patient (99214)	$183.83	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the procedures for determining the fee schedule for professional services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed CPT Code 99214 with claim adjustment reason codes "CAC-150 – Payer deems the information submitted does not support this level of service," "225 – The submitted documentation does not support the service being billed," and "890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems."

   28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Detailed History:
     - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions." Documentation found five points of HPI were reviewed, thus meeting this element.
     - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented." Documentation found one system (musculoskeletal) reviewed. This element was not met.
     - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] to be documented." The documentation supports that two history areas were reviewed. This element was not met.

The Guidelines state, "To qualify for a given type of history all three elements in the table must be met." A review of the submitted documentation indicates that two elements were met for a Detailed History, therefore this component of CPT Code 99214 was not supported.

- Documentation of a Detailed Examination:
    - A "*detailed* [examination] …should include performance and documentation of at least twelve elements [of the Musculoskeletal Examination table]." A review of the submitted documentation finds that nine elements were documented. Therefore, this component of CPT Code 99214 was not met.
- Documentation of Decision Making of Moderate Complexity:
    - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that there were no new diagnoses presented, and that established diagnoses were stable or improving, meeting the documentation requirements of minimal complexity. Therefore, this element was not met.
    - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered no diagnostic testing and did not review documentation from another party. The documentation does not support that this element met the criteria for moderate complexity of data reviewed.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problem includes one stable chronic injury, which presents a low level of risk; no diagnostic procedures were ordered; and prescription drug management options were discussed. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for moderate risk.

"To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation does not support that this component of CPT Code 99214 was met.

Because none of the required components of CPT Code 99214 were met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203.

2. For the reasons stated above, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	July 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.